IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
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BUREAU OF FACILITY STANDARDS
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July 23, 2010

Teresa Carpenter
Preferred Community Homes - Courtyard
615 Second Avenue West
Wendell, ID 83355

RE: Preferred Community Homes - Courtyard, provider #13G057

Dear Ms. Carpenter:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Courtyard, which was conducted on July 16, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 4, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by August 4, 2010. If a request for informal dispute resolution is received after August 4, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Trish O'Hara

TRISHA O'HARA
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/srp

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

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W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Trish O'Hara, RN - Team Lead Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: ADHD - Attention Deficit Hyperactive Disorder GERD - Gastroesophageal Reflux Disease IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record PRN - As Needed QMRP - Qualified Mental Retardation Professional	W 000	**W 000 INITIAL COMMENTS** "Preparation and implementation of this plan of correction does not constitute admission or agreement by Courtyard with the facts, findings or other statements as alleged by the state agency dated July 16, 2010. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Courtyard -- Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the individual program plan described relevant interventions to support independence for 1 of 3 individuals (individual #3) whose IPPs were reviewed. This resulted in insufficient information being available to staff related to an individual's supervision needs. The findings include: 1. Individual #3's 2/16/10 IPP stated he was a 12	W 240	**W 240 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN** All Individual Program Plans will be reviewed and revised to ensure that specific information related to their needs is included in the IPP document. The Assistant QIDP will be responsible and the QIDP will monitor and review all IPP's to ensure compliance with this regulation. Core team meetings will be conducted quarterly to review and monitor all residents IPP documents. Person Responsible- AQIDP. Completion Date- 10/08/2010. Monitoring- Quarterly.	

RECEIVED
AUG 30 2010
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: I am MRA — TITLE: Adm Assistant — (X6) DATE: 8/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 240	Continued From page 1 year old male whose diagnoses included profound mental retardation, ADHD, and autism. During observations conducted at the facility on 7/13/10 from 5:45 - 6:45 a.m. and 1:00 - 2:20 p.m., Individual #3 was observed to have one staff working with him at all times. The staff was not observed to leave Individual #3's side. Individual #3's record included a General Information sheet, undated, which stated he was "one on one staff/client ratio." However, no additional information could be found in the record, and the IPP did not include information related to Individual #3's need for one on one staffing. During an interview on 7/16/10 from 10:05 - 11:25 a.m., the Administrator and QMRP both stated Individual #3's one on one staff supervision was due to the severity of his ADHD. The QMRP stated Individual #3 was so easily distracted it required one staff just to keep him on task. The QMRP stated Individual #3's one on one needs had not been included in the IPP. The facility failed to ensure Individual #3's IPP included specific information related to his one on one supervision needs.	W 240		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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W 249	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure each individual received training and services consistent with their IPP for 1 of 3 individuals (Individual #4) who required one on one supervision. This resulted in an individual not receiving supervision as specified in their IPP. The findings include: 1. Individual #4's 3/12/10 IPP stated he was a 21 year old male whose diagnoses included moderate mental retardation. During an observation at the facility on 7/13/10 from 1:00 - 2:20 p.m., Individual #4 was noted to have a staff working specifically with him. When asked, the staff stated Individual #4 required one on one supervision which meant staff were to remain within arms length of him at all times. However, during the observation the staff working with Individual #4 was noted to leave him alone on no less than six times, including staff leaving him to go to the back of the facility and into the kitchen for up to five minutes. Individual #4's Behavior Intervention Program, revised 3/12/10, stated one on one staff were to work with no other individuals, and were to remain within a "literal arm's length" of Individual #4 at all times during waking hours. When Individual #4 was in the bathroom, staff were to stand outside of the bathroom door. During an interview on 7/16/10 from 10:05 - 11:25 a.m., the Administrator and QMRP both stated	W 249	**W 249 483.440(d)(1) PROGRAM IMPLEMENTATION** All staff will be trained on all individual's behavior intervention programs which includes methods and practices on individual needs and supervision levels. All staff will be trained continuously on a Quarterly basis. RSC will monitor through observations and on the spot training. Person Responsible- AQIDP. Completion Date- 10/08/2010. Monitoring- Quarterly.	

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W 249	Continued From page 3 staff working with Individual #4 should not have left his side as observed. The facility failed to ensure Individual #4's Behavior Intervention Program was implemented.	W 249		
W 300	483.450(d)(3) PHYSICAL RESTRAINTS The facility must not issue orders for restraint on a standing or as needed basis. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure standing restraints were not in place for 1 of 2 individuals (Individual #1) whose restraint information was reviewed. This resulted in an individual having a restraint in place that was not in use. The findings include: 1. Individual #1's 11/4/10 IPP stated he was an 18 year old male whose diagnoses included moderate mental retardation and seizure disorder. He was admitted to the facility on 10/5/09. Individual #1's Behavior Intervention Program, dated 3/22/10, stated he engaged in physical aggression, defined as hitting, kicking, biting, grabbing, and scratching. The program stated "If restraint is used (Walking-moving restraint) the reason why and the length of time that it was needed, must be documented on the behavior slip." However, Individual #1's record did not document a walking-moving restraint had ever been used. During an interview on 7/16/10 from 10:05 - 11:25 a.m., the Administrator stated no restraint had	W 300	**W 300 483.450(d)(3) PHYSICAL RESTRAINTS** Individual #1's Behavior Intervention Plan has been revised and the walking-moving restraint has been removed. In addition to this all of the Behavior Management Plans are being reviewed to verify that there are not physical restraints in the programs that are not being utilized. The AQIDP is receiving training in regards to the use of physical restraints. The program Administrator will do quarterly reviews to the QIDP books, one part of the review will include reviewing the use of all the restraints to verify that there are no unused restraints in the books. If the program Administrator locates any restraints that are not needed, they will be responsible to work with the AQIDP to remove the restraints from the books. Person Responsible- Program Administrator. Completion Date- 10/08/2010. Monitoring- Quarterly.	

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W 300	Continued From page 4 been required since Individual #1's admission to the facility on 10/5/09. The Administrator stated the restraint had been added as a precaution and needed to be removed. The facility failed to ensure Individual #1's unused restraint procedures were removed from his program.	W 300		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the pharmacist conducted comprehensive drug regimen reviews with accurate input from the IDT. This directly impacted 1 of 3 individuals (Individual #2) whose pharmacy consultations were reviewed, and had potential to impact all individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for negative health outcomes due to inaccurate allergy documentation. The findings include: 1. Individual #2's 11/4/09 IPP stated he was a 17 year old male whose diagnoses included severe mental retardation, autism, seizure disorder, and GERD. Individual #2's Nurse's Notes, dated 12/4/09, stated "neurology aware allergic reaction valium d/c [discontinue] valium [sic]." However, Individual #2's MAR documented he received diazepam (Valium - an anxiolytic drug) 20 mg on 12/14/09. His MAR did not include information	W 362	**W 362 483.460(j)(1) DRUG REGIMEN REVIEW** Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor the nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents. All resident's medical records will be reviewed and updated to include accurate and complete information. Pharmacist will do quarterly reviews of all medication. RN will follow pharmacist review with her own review to be completed quarterly. Person Responsible- LPN and Registered Nurse, and Pharmacist. Completion Date- 10/08/2010. Monitoring- Quarterly.	

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W 362	Continued From page 5 regarding allergies. Additionally, a 10/8/09 letter from Individual #2's neurologist stated "He is allergic to Diastat [an anxiolytic drug]." Individual #2's pharmacy reviews, dated 12/17/09 and 3/15/10, did not include information regarding an allergic reaction to Valium or Diastat. During an interview on 7/16/10 from 10:05 - 11:25 a.m., the Administrator stated the facility's LPN took individuals' medical records to the facility's corporate office for review by the pharmacist. At that time, the pharmacist was to review all documentation in the medical record. The Administrator stated Individual #2's allergic reaction was specific to Diastat and that he did not have a reaction to Valium in pill form. The Administrator stated she was not sure how the information was missed in the pharmacy review process. The facility failed to ensure sufficient information was provided to the pharmacist to complete accurate and thorough reviews.	W 362		
W 363	483.460(j)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure irregularities in individuals' drug regimens were reported to the prescribing physician and IDT by the pharmacist for 1 of 3 individuals (Individual	W 363		

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W 363	Continued From page 6 #2) whose pharmacy records were reviewed. This resulted in the physician and IDT not being informed of an individual receiving medications for which physician's orders had not been obtained. The findings include: 1. Individual #2's 11/4/09 IPP stated he was a 17 year old male whose diagnoses included severe mental retardation, autism, seizure disorder, and GERD. Individual #2's MAR were reviewed from 8/09 - 7/13/10 and documented he received the following PRN drugs: - 12/3/09: imodium (an antidiarrheal drug) 20 mg. - 3/6/10: acetaminophen (a nonopioid analgesic drug) 1000 mg. However, Individual #2's record did not contain a physician's order for the use of imodium or acetaminophen. Individual #2's pharmacy reviews, dated 3/18/10 and 6/17/10, did not include documentation of Individual #2 receiving unprescribed medications. The pharmacist failed to identify the medication errors and report to the physician. During an interview on 7/16/10 from 10:05 - 11:25 a.m., the Administrator stated the facility's LPN took individuals' medical records to the facility's corporate office for review by the pharmacist. At that time, the pharmacist was to review all documentation in the medical record including individuals' MAR and physician's orders. The Administrator stated she did not know how the unprescribed medications were overlooked.	W 363	**W 363 483.460(j)(2) DRUG REGIMEN REVIEW** Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor the nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents. Doctors' orders will be obtained for all medications given to residents. Pharmacist will do quarterly reviews of all medication. RN will follow pharmacist review with her own review. Person Responsible- Physician, Registered Nurse, and Pharmacist. Completion Date- 10/08/2010. Monitoring- Quarterly.	

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W 363	Continued From page 7 The facility failed to ensure the pharmacist reported Individual #2's receipt of unprescribed drugs to the physician and IDT.	W 363		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure all medications were administered in compliance with physician's orders for 1 of 3 individuals (Individual #2) whose medication administration records were reviewed. This resulted in an individual receiving medications that had not been ordered by the physician. The findings include: 1. Individual #2's 11/4/09 IPP stated he was a 17 year old male whose diagnoses included severe mental retardation, autism, seizure disorder, and GERD. Individual #2's MAR were reviewed from 8/09 - 7/13/10 and documented he received the following PRN drugs: - 12/3/09: imodium (an antidiarrheal drug) 20 mg. - 3/6/10: acetaminophen (a nonopioid analgesic drug) 1000 mg. However, Individual #2's record did not contain a physician's order for the use of imodium or acetaminophen. During an interview on 7/16/10 from 10:05 - 11:25 a.m., the LPN stated Individual #2 did not have an	W 368	**W 368 483.460(k)(1) DRUG ADMINISTRATION** Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor the nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents. Doctors' orders will be obtained for all medications given to residents. Pharmacist will do quarterly reviews of all medication. RN will follow pharmacist review with her own review. Person Responsible- Physician, Registered Nurse, and Pharmacist. Completion Date- 10/08/2010. Monitoring- Quarterly.	

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W 368	Continued From page 8 order for the use of imodium or acetaminophen. The facility failed to ensure individual #2's medications were given in compliance with physician's orders.	W 368		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure individuals received food consistent with their prescribed diets for 1 of 1 individuals (Individual #1) reviewed who were to receive specialized dietary textures. This resulted in the potential for an individual to experience swallowing difficulties and possible aspiration. The findings include: 1. Individual #2's 11/4/09 IPP stated he was a 17 year old male whose diagnoses included severe mental retardation, autism, seizure disorder, and GERD. His record documented he had a fundoplication procedure (a surgical procedure in which the upper curve of the stomach is wrapped around the esophagus and sewn into place, which stops acid from backing up into the esophagus as easily) completed on two different occasions. During an observation on 7/13/10 from 5:45 - 6:45 a.m., Individual #2 was observed to eat breakfast consisting of a banana, a muffin, and a hard boiled egg. The staff chopped Individual #2's food into a mechanical soft consistency.	W 474	**W 474 483.480(b)(2)(iii) MEAL SERVICES** Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor the nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents. During the quarterly review the RN will be reviewing all records to verify that orders are clear. If any of the dietary orders are not clear, immediate revisions will need to be made. All staff will be trained on specific dietary orders and guidelines. RSC will do meal observations weekly. Person Responsible- QIDP, Dietitian, RN, and RSC. Completion Date- 10/08/2010. Monitoring- Weekly.	

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W 474	Continued From page 9 A Nurse's Notes, dated 10/29/09, stated Individual #2 was taken to the hospital for a "scope [and] poss [possible] dilation of previous fundoplication. Will continue pureed diet." Individual #2's record included a Physician's Order Sheet and Progress Notes, dated 2/17/10, which stated "puree diet until further notice." During an interview on 7/16/10 from 10:05 - 11:25 a.m., the Administrator and LPN both stated Individual #2's diet order changed between pureed and mechanical soft depending on his stability with regards to his fundoplication. The Administrator stated Individual #2 would undergo dilation procedures to stretch the opening in the esophagus. Following dilation, Individual #2 would be able to eat a mechanical soft diet. The esophageal opening would then begin to tighten over time causing Individual #2 to regurgitate food. At that time, the diet order would be changed to pureed until the physician rescheduled dilation. The Administrator stated Individual #2's last dilation was completed 2/14/10 and stated she believed he should be receiving a mechanical soft diet. The Administrator stated the diet orders were not clear. The facility failed to ensure Individual #2 received a diet in a texture consistent with his needs.	W 474		

Bureau of Facility Standards

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MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties: and This Rule is not met as evidenced by: Refer to W249.	MM212	**MM 212 13.03.11.075.17(a) MAXIMIZE DEVELOPMENTAL POTENTIAL** Please refer to 249	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for individuals having access to toxic chemicals. The findings include: 1. During an environmental review on 7/15/10 from 10:00 - 10:50 a.m., the following toxic chemicals were found to be unlocked: a. Under the kitchen sink: - Two 1 quart bottles of Clorox Clean Up with Bleach. - A can of Sprayway Glass Cleaner. b. In the laundry room: - A 1.4 gallon bottle of Clorox Clean Up with Bleach. - A 1 quart bottle of Clorox Clean Up with Bleach. - 3 cans of Sprayway Glass Cleaner. The MSDS (Material Safety Data Sheet) for	MM271	**MM 271 16.03.11.100.04(b) STORAGE OF TOXIC CHEMICALS** The facility has been inspected and currently all chemicals are labeled and under lock and key. Training will be provided to all employees on the regulation and all staff will ensure all chemicals are properly labeled and locked. In addition, the program Administrator will be assigned to do monthly inspections of the facility. One part of the inspections includes the Administrator looking for any chemicals that are not labeled or kept under lock and key. In the event that any chemicals are located that are not labeled or under lock and key, immediate corrective action will occur. Person Responsible- RSC. Completion Date- 10/08/2010. Monitoring-QIDP, Quarterly.	

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FACILITY STANDARDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

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MM271	Continued From page 1 Clorox Clean Up with Bleach stated the product could irritate skin, eyes, nose, throat, and lungs, and was harmful if swallowed. The MSDS for Sprayway Glass Cleaner stated the product was classified as a "Hazardous Chemical" and was harmful to skin, kidneys, blood, and liver. The Residential Service Coordinator, who was present during the review, stated the chemicals should have been locked. The facility failed to ensure all toxic chemicals were maintained under locked conditions.	MM271		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: An environmental review was conducted on 7/15/10 from 10:00 - 10:50 a.m. During that time the following was noted: - The refrigerator to the left of the sink in the	MM380	**MM 380 16.03.11.120.03(a) BUILDING AND EQUIPMENT** **The Facility's maintenance person will ensure that all environmental repairs as listed in the deficiency are repaired and maintained. RSC will do weekly environmental checks to ensure maintenance in the facility is maintained.** **Person Responsible- RSC. Completion Date- 10/08/2010. Monitoring-QIDP, Quarterly.**	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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MM380	Continued From page 2 kitchen was missing the rails to the bottom two door shelves. - The caulking between the counter and splash board behind the kitchen sink was missing. - The top of the door frame on the dishwasher to the right of the kitchen sink was broken preventing the door from closing properly. - There was a 3 foot section of the wall in the dining room where the dining chairs had removed paint and finish from the wall. - There was a 3 inch hole in the wall to the left of the storage closet in the dining room. The facility failed to ensure environmental repairs were maintained.	MM380		
MM678	16.03.11.250.08(c) Individual Resident's Needs Foods must be served in a form to meet individual resident's needs: This Rule is not met as evidenced by: Refer to W474.	MM678	**MM 678 16.03.11.250.08(c) INDIVIDUAL RESIDENT'S NEEDS** Please refer to W 474	
MM757	16.03.11.270.02(f)(iii) Signed Physician's Order No resident can receive any medication unless his record contains a current and signed physician's order for such medication. This Rule is not met as evidenced by: Refer to W368.	MM757	**MM 757 16.03.11.270.02(f)(iii) SIGNED PHYSICIAN'S ORDER** Please refer to W 368	
MM758	16.03.11.270.02(f)(iv) Medication System Monitored	MM758		

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MM758	Continued From page 3 The resident's medication system must be evaluated and monitored on a regular basis by a registered nurse and/or a licensed pharmacist. Such evaluations must be done at least every thirty (30) days and records of the evaluation, as well as action taken to correct noted problems, must be kept on file by the facility administrator. This Rule is not met as evidenced by: Refer to W362 and W363.	MM758	**MM 758 16.03.11.270.02(f)(iv) MEDICATION SYSTEM MONITORED** **Please refer to W 362 and W 363**	
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W240.	MM855	**MM 855 16.03.11.270.08(c) TRAINING AND HABILITATION RECORD** **Please refer to W 240**	